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AAA Board Member Jimmy Johnson, Life Emergency Medical Service, and Ann Singer, EMSA, prepare for a visit to a Senate office during AAA's Lobby Days in March.

Repeat Admissions and Interrupted Stays – ONE YEAR LATER

By Brian Werfel, Esq.

On September 5, 2005, the Centers for Medicare and Medicaid Services (CMS) issued Transmittal 668 (C.R. 3933), which implemented new edits to Medicare's Common Working File intended to identify—and deny—ambulance transportation furnished to hospital inpatients. These edits, which went into effect January 3, 2006, have introduced two new terms into the ambulance biller's vocabulary: the "repeat admission" and the "interrupted stay."

Background

Medicare Part B does not pay for ambulance transportation furnished to a beneficiary during an inpatient stay. For this reason, an ambulance service must know whether the person being transported is a hospital "inpatient" or not.

Normally, this determination is straightforward: the person becomes an inpatient at the time he or she is admitted to the hospital, and ceases to be an inpatient when he or she is discharged. But what

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NATIONAL PROVIDER IDENTIFIER (NPI)

By: David M. Werfel, Esq.

May 23, 2007 is coming quickly. **If you do not get this issue right, all of your medicare claims will be denied.**

There are actually two NPI issues. The first is your NPI; the other is the NPI for the referring source.

Your NPI

If you have not yet applied for your National Provider Identifier (NPI), do so immediately. Effective **May 23, 2007,** you will no longer be allowed to use your current Medicare ID number. Only the NPI will be allowed. You can apply for the National Provider Identifier (NPI) in one of three ways.

- Apply on line at: https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart
- Agree to have an Electronic File Interchange Organization submit the application data for you.
- Obtain a copy of the paper NPI Application/Update Form (CMS-10114) and mail the completed, signed application to the NPI Enumerator. They can be contacted via:
  - **Phone:** 1-800-465-3203
  - **E-mail:** customerservice@npienumerator.com
  - **Mail:** NPI Enumerator, P.O. Box 6059, Fargo, ND 58108-6059

More information on the NPI can be found on the CMS NPI web page: www.cms.hhs.gov/NationalProvIdentStand.

NPI of Referring Physician

A second problem – and there is some confusion with some carriers – involves the NPI of the referring physician. Box 17b on the new 1500 form is for the NPI of the referring physician. Ambulance providers and suppliers should not fill in this box, unless a physician actually is the referring source.

Please note, if you currently list a UPIN, or a surrogate UPIN (e.g. SLF000 or OTH000), on your claims, it will no longer be allowed as of May 23, 2007.

In some meetings around the country, carriers have stated that an NPI must be listed in Box 17b. They are forgetting to state that it must be listed in 17b only if there is a referring physician (which is what is stated in Pub. 100-04, Chapter 26, section 10.4).

Perhaps they are getting this from a MLN Matters article, MM 5060, Revised, http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5060.pdf which states (starting at the bottom of page 2): "When the NPI number is effective and required (May 23, 2007, although it can be reported starting January 1, 2007), claims will be rejected (in most cases with reason code 16 – "claim/service lacks information that is needed for adjudication") in tandem with the appropriate remark code that specifies the missing information, if the appropriate NPI is not entered on Form CMS-1500 (08-05) in items…17B (replacing item 17 or 17A, Form CMS-1500 (12-90));…"

"Required" was meant to mean when it is required because there is a referring physician.

Enrollment Form – NPI

One final note - - the revised CMS 855 Medicare provider enrollment application must include the NPI. No initial application can be approved and no updates to existing enrollment information can be made without this NPI information. Thus, all health care providers and suppliers who bill Medicare are required to obtain their NPI in advance of enrolling or changing their Medicare enrollment data.

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One Year Later

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happens when the person is readmitted to that same hospital (or, in some cases, to a similar facility) within a relatively short period of time? When this occurs, Medicare may require the hospital to combine the two stays into a single stay. In effect, Medicare will disregard the initial discharge, and will treat the person as if he or she had remained an "inpatient" during the interim period between the two stays. As a result, ambulance transportations furnished during this interim period would no longer be payable by Part B, i.e., the trips become the responsibility of the hospital.

So when should you bill the hospital? That answer depends on a number of factors, the type of facility to which the person was admitted, whether the person was formally discharged from that facility, the length of his or her absence from that facility, and the reason for that absence.

A "repeat admission" occurs whenever a person is discharged from an acute care hospital and later readmitted to the same acute care hospital on the same calendar day for treatment of the same condition. This definition is contained in CMS Internet Manual, Pub. 100-04, Chapter 3, Section 40.2.5. When a repeat admission occurs, the hospital is responsible for any ambulance trips provided to the person on that day, even where the trip back to the hospital was an emergency. If, however, the person was readmitted to that hospital for an unrelated condition, then the two stays would not be combined, and Part B would be responsible for any ambulance trips provided.

An "interrupted stay" occurs whenever a patient is discharged from a psychiatric facility (IPF), rehabilitation facility (IRF) or a long-term care hospital (LTCH), and is readmitted to the same facility (or, in the case of a psych inpatient, to another IPF) within a certain period of time. These definitions are set forth in the Code of Federal Regulations and also in the CMS Internet Manual, Pub. 100-04, Chapter 3, Section 140.2.3 (IRF), Section 150.9.1.2 (LTCH), and Section 190.7.1 (IPF). For ambulance purposes, bill as follows:

- IPF – bill the facility when the person is discharged and returns on the same calendar day. If they return to another IPF on that same calendar day, bill the first IPF. If the person does not return on the same calendar day, bill Part B.
- IRF – bill the facility when the person is discharged and returns within three calendar days, unless the person was admitted to an acute care hospital and stayed there for at least one night, in which case bill Part B.
- LTCH – bill the facility when the person is discharged and returns within three calendar days.

One area of confusion involves those situations where the facility does not discharge the patient. By definition, an interrupted stay occurs only when the person is discharged and readmitted. If the person is never discharged, the inpatient stay would continue, uninterrupted, and the facility would remain responsible for any ambulance transportation. For example, an inpatient at an IPF has a physical emergency and is taken to the ER by ambulance. At the time of the emergency, the IPF does not know whether the patient will be admitted to the acute care hospital, or whether they will be seen in the ER and released. As a result, they may hold the patient's bed open and not discharge them. When the patient returns to the IPF, this would not be an interrupted stay, because the patient had never been discharged, and the hospital would be responsible for the ambulance trips.

Getting Information

The major issue ambulance services face in complying with these new rules is a lack of information, i.e., the first time an ambulance service may know the patient was an inpatient of a facility is when they get a denial after billing for the transport. While this problem can not be eliminated, there are some steps you can take to help identify these trips. Unfortunately, these suggestions may not be practical for all ambulance services. For repeat admissions, you may want to see if your computer system can be programmed to identify multiple trips for the same patient on the same day. For interrupted stays:

- identify each IPF, IRF and LTCH in your area.
- see if your computer system can be programmed to "tag" trips originating out of these facilities. This would tell you trips that might be part of an interrupted stay. You would then need to follow up with the facility to determine when (or if) the patient returned.
- obtain access to a hospital Part A terminal, or access patient eligibility information directly from CMS through the Extranet.
- if practical, contact the facility for admission and discharge dates.

Carrier Activities

While the ambulance industry has struggled with these new rules, Medicare Contractors have been actively trying to recover monies previously paid to ambulance services. Recovery Audit Contractors (RACs) in California and Florida have been sending overpayment notices to ambulance services, seeking repayment for repeat admissions and interrupted stays going back to 2002. The RACs have been joined in recent months by Carriers in other states, again seeking recovery on overpayments going back to 2002. Carriers have not been consistent in how they are trying to recover the money. For example:

- some Carriers are sending out overpayment letters for 2002 – 2005 in a single batch.
- other Carriers are sending the overpayment letters out one year at a time.
- still other Carriers are sending the overpayment letters out on a claim by claim basis.
- finally, some Carriers have not yet issued overpayment letters.

We have also seen overpayment letters referencing trips for which the ambulance service previously refunded the money, e.g., where the ambulance service later learned that the facility was responsible.

Lastly, Carriers have been conducting educational sessions on these issues. Unfortunately, these sessions have, at times, further confused the issue. For example, one Carrier has suggested that ambulance services hold their claims for 30 days and call the destination hospital for all transports, before billing.

Crossing Midnight

A related problem involves hospital to hospital transports occurring at or close to midnight. Because the Common Working File (CWF) edits are based on calendar days, ambulance trips that should be paid by Part B are being denied, as a result of simple date-keeping mistakes by ambulance services,

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hospitals, or both.

Take the following example: Mr. Smith is an inpatient in a psychiatric hospital. At 11:55 p.m. on March 1, Mr. Smith begins to experience mild chest pain, and an ambulance is called. The ambulance arrives at 12:05 on March 2, 2007 and transports him to the ER. Mr. Smith is seen in the ER and ultimately admitted to the hospital, where he remains until March 3. This is a standard hospital to hospital transfer, where the patient has been discharged from the first facility and admitted to the second facility for an elevated level of care. Therefore, it should be paid by Part B.

When the psychiatric hospital submits its claim, it may list the patient's date of discharge as March 1 or March 2. The ambulance service may list its date of service as March 1, the date the ambulance was called, or March 2, the date transported. Depending on the dates listed by the hospital and the ambulance service, the ambulance claim may be denied, because Medicare will show that Mr. Smith was an inpatient of the psychiatric hospital on March 1.

The lesson here: when the trip occurs at or close to midnight, you may get an unwarranted denial from Medicare. When this happens, try to get the hospital discharge record, and appeal, if necessary.

Paying Attention to Detail…

The Road to a Successful Operation

By Patrick J. Twomey
President & CEO, Access EMS

When I started this profession at the age of 18, I took it pretty seriously. I worked hard to achieve success and to progress up the food chain. However, being so young, there were times when my superiors wanted things done a certain way that I thought was ridiculous or a complete waste of my time. It wasn't until I held positions as Director and progressed to having visions of my own company that I realized why my past "bosses" were so particular about having things done their way. Now, I'm not saying that their way was always correct, or that all of the people I worked for over the years cared about operations, and I am not a proponent of micromanagement, but I have to tell you, the ones that did succeed, paid attention. If I have taken anything away from everyone I worked for, it is to pay attention to detail.

Here are some of the simple things that I feel we as leaders need to focus on in order to pave the way to success.

• We need to have a clear mission. As corny as some mission statements may sound, it truly sets the tone for the organization. People interested in coming to work with you can either accept or reject it at the outset. They will have a clear understanding of where you see your operation going.

• When we appoint managers that have worked within the system and deserve a promotion, we need to oversee them and not let them flounder. We need to give them the tools necessary to succeed. We have a reputation to uphold, and they are going to be carrying out the mission. We need to be there to answer questions and to give proactive and productive advice. If they fail, we as leaders have failed. Overall, the mission has failed and the company reputation will slide.

• Do not take a contract for granted. When we sign a contract with a city, town, or a health care facility, we cannot view this as time to slack off. We must constantly analyze our service and assure that they are getting what we all promise when we are presenting our organization to the decision makers. We must arrive on time, be friendly, and introduce ourselves to our patients. We must take a quick report on our patients and treat them like the VIP's they are.

• We must never misrepresent. We must not shift resources to barely maintain. In other words, do not "rob Peter to pay Paul". Utilize competitors to help your operation out. You will be respected for it and you will maintain contracts.

• Respect is a two way street. This applies to contracts and employees. Sometimes company's want business so bad that they trade in their self respect and make unrealistic promises to get the work. When presenting a pitch for more business, work into your presentation that you expect to be treated as they do. Don't sell yourself short to make a gain in yardage. It gets noticed. You loose respect quickly, both internally and externally. Some folks who are soliciting for ambulance contracts know this quite well, and take advantage of the cutthroat, competitive nature of our business. They set us up to the point that we won't even help each other out. This isn't what we are about.

• When we are hiring our employees, we must look for personality, not just clinical ability. We must have team members that treat a transfer to a nursing home with as much importance as a cardiac arrest off the street. All of our customers are important. We must do the best we can to have fun with our team on a daily basis and provide them with the best benefits we can afford, competitive wages, and a comfortable clean crew area that they can be proud of and enjoy. Remember, if it weren't for your team, you wouldn't have a company. If they are not happy (within reason of course), it will reflect in their work. They are the most effective marketing group you will have. Take care of them!

Don't lose sight of your mission, your team, your goals, your mission, or most importantly, your self-respect. Pay attention to the details of your operation and you will be successful.

Patrick J. Twomey is President & CEO of Access EMS, in Concord, New Hampshire. He opened Access EMS, a private ambulance service, in April of 2006. He has been an active Nationally Registered Paramedic for the past 21 years. He is also the President of the New Hampshire Ambulance Association. Over his 23 years in EMS, his management and clinical experiences have taken him beyond the private ambulance sector. He has also been involved with hospital based systems and air medical.

BENCH STRENGTH IN THE AMBULANCE INDUSTRY?

By Matt Zavadsky Tri-State Ambulance

While attending and speaking at two national EMS conferences this summer, it occurred me that we have a looming crisis in our industry… the significant lack of "Bench Strength". Bench strength refers to a qualified field of replacement players. In the ambulance industry, this specifically applies to those people qualified and ready to step up to management, chief executive positions, or true industry leaders such as Jay Fitch, Jack Stout, Jerry Overton and others who have helped shape current and future EMS systems across the nation and around the world.

There are probably several reasons for this phenomenon. First, we are a 'young' industry by most standards. Modern EMS has only really been around since the 1970s. As such, there is a dearth of formal education programs for EMS management. EMS professionals who wish to pursue an actual degree in EMS have very limited choices and programs with actual Bachelor's or Master's level programs are extremely difficult to find.

Second, many of us who grew up watching "EMERGENCY!" and got into this business in the late 70's, are reaching our maximum useful professional life (yes Jerry, even you may retire someday!). The hyper-turbulence of EMS life often pushed issues such as succession planning to a back burner. Consequently, we have not cultivated self-replacements two or three people deep.

Finally, our industry has not historically placed a lot of value on formal education, or even management training in general for that matter. Promotions have been more commonly made based on street experience, excellent clinical skills, or some type of promotional-civil service examination process. This poses a problematic conundrum; we have a host of middle and senior managers without degrees who in turn, do not see the value in formal education. Couple that with the virtual wasteland of EMS degree programs and "presto", the current state of a weak bench!

If you are in a management or leadership position, you owe it to your organization, your community and our industry to develop a succession plan for your role. Years ago I was blessed to be a senior manager for Rural/Metro. One of the main responsibilities we all had (and a responsibility which was a main component of our performance appraisals) was the development and implementation of succession plans for myself, as well as assuring all managers on my team also had succession plans. This was a very wise strategy since good managers were often offered promotions to other areas and developing your replacements helps make you 'available' to be promoted.

IF YOU ARE IN A MANAGEMENT OR LEADERSHIP POSITION, YOU OWE IT TO YOUR ORGANIZATION, YOUR COMMUNITY AND OUR INDUSTRY TO DEVELOP A SUCCESSION PLAN FOR YOUR ROLE.

How do you develop a good succession plan?? Here are some key concepts you can use to build your bench!

In some cases, deciding on a replacement can be an immediate and obvious gut decision. In other cases, it may be less obvious and more difficult. Succession Plans are usually confidential documents containing the names of people designated as immediate or long-term successors. By themselves, Succession Plans are neither developmental plans nor a means to motivate designated successors. They are, however, a trigger for targeted development of potential successors.

Before initiating the planning process determine which key positions you feel require a Succession Plan. Obviously, your own position, but also consider requiring your entire management team to create succession plans for their positions as well. In doing so, assure them that the need for creating a succession plan IS NOT because their current employment is at risk, but rather a way to be sure they are 'promote-able' if that option becomes available.

Consider potential successors in light of their abilities and their demonstration of the core values you feel are important to the mission and vision of the organization. You do not need to limit potential successors to those within your immediate organization or even those within the EMS industry. If the position is truly management/leadership, the core skills are the key element. Anyone can be taught the EMS business. In fact, there is often great debate on whether it's easier to take a field medic and teach them management and leadership skills, or hire a person with great management and leadership skills and teach them the EMS business. My bias is to the latter.

Once you identify a successor, or two, share with them your opinion that you feel they would be a good successor.

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AAA Best Practice on Flu Vaccination for EMS Personnel: One Company's Implementation Experience

By Larry S. Anderson, L.F.A.C.H.E.

As the drafter of the Michigan Association of Ambulance Services' and AAA's Best Practices on Flu Vaccination for EMS Personnel, I only felt it appropriate to provide information on LifeCare Ambulance Service's successful attempt at implementing the Best Practice for the 2006-2007 flu season.

What is a "Best Practice"?

A best practice is the continuous process of learning, feedback, reflection and analysis of what works and why. Best practices are the documentation of what works. Over the past 20 years, best practices have been adopted by hospitals and the health industry as a mechanism to improve quality and/or reduce the cost of patient care. With the huge disparity in outcomes, length of stay, complications, and costs, medical specialties began a peer process to examine the variability in their practices. They documented as best practices the procedures and policies of physicians whose patient outcomes were the best. The best practices then become benchmarks for comparison. The process leads to an overall improvement of patient care without resulting in "cookbook" medicine.

Best practices provide a framework for improvement but should not be adopted in total without analysis of the local circumstances. They may be adapted, modified, and improved with an end goal in mind.

AAA Best Practice on Flu Vaccination for EMS Personnel

The Best Practice can be viewed on the American Ambulance Association's web site. Historically, LifeCare Ambulance Service has paid for flu vaccinations for staff and members of our volunteer board of directors. Our best guess is that less than 20% ever received the vaccine and the largest group vaccinated was the board of directors. With the current flu season under the Best Practice, more than 65% of our staff and board members are currently vaccinated.

As with many physicians, medics focus on their individual patients and one-on-one compassionate care, seldom stepping back to look at the larger patient care issues. Given the option, they would just as soon not receive a needle injection of flu vaccine. Studies indicate that less than 38% of healthcare providers subject themselves to the flu vaccine and that EMS services may be well below that figure.

This Best Practice was developed on the premise that we do no harm to patients. Over 50 % of our patients are 65 or older and many, especially those transferred between nursing homes and hospitals, may have compromised immune systems making them easy targets for flu and its potential life threatening complications. With low rates of flu vaccination among medics, flu can rapidly spread among an EMS services' staff and from staff to patients.

Other unintended consequences include higher absenteeism impacting upon ambulance staffing, overtime, medic burnout from mandated overtime to cover for sick staff, as well as the potential of infecting one's own family members.

Thus the Best Practice was developed to counter the potential exposure to patients, our medics and support staff, and their families.

Planning considerations:

- Start early – we started vaccinations in October 2006 and started planning in September 2006
- Determine who will administer the vaccinations – your paramedics, a hospital, a private physician, or an occupational health facility; cost may be a consideration
- Vaccine supply – confirm with whomever will administer the vaccine the delivery date for vaccine and quantity (over the past several years there have been problems with supply and or distribution); check with your local public health agency
- Confirm your company's decision on paying for the flu vaccine and its administration for each employee
- Consider incentives for staff to get vaccination
    - o Drawing for prizes to include lunch with CEO, car washes and detailing by managers, electronic devices, etc.
    - o We tied vaccination at various occupational health centers across our 1,200 sq. mile service area to the same time period and places for their mandatory semi-annual TB test which added convenience
    - o Competition among employee teams
- Register vaccinations with the state– in Michigan the local health departments are responsible for assuring that persons who receive vaccinations are added to a state registery; those administering vaccines must capture the data for the computerized registry and for the ambulance service's employee health records

Making It Happen

- Educate employees
- Do no harm to your patients, to yourself, to your family, and to your colleagues
- Explain differences between live and dead virus
- Explain differences between vaccination with needle and syringe and inhaled Flu Mist (the latter is likely to be more expensive)
- Explain the impact of flu on staffing, overtime, scheduling
- Seek commitment from people
- Remove any external barriers
- Publicize
    - o Use posters, notes on pay checks, e-mail, and management, supervisory staff, and clinical leaders
    - o Use effective communication techniques such as vivid media, language, etc., know your audience, use credible sources, etc.
    - o Use prompts such as stickers on employee communications, news letter, signs on light switches, etc.
- Policy regarding employee refusal to take vaccine – develop a human resources policy that fits the needs of your organization

A New Focus on Flu:

- Joint Commission on HealthCare Organizations developed a new standard requiring hospitals, as of January 1, 2007, to assure all employees, physicians, and volunteers have access to flu vaccine at the hospital's expense
- This past year the board of directors of Bronson Medical Center in Kalamazoo, Michigan, after learning of the low flu vaccination rate for physicians and hospital staff, mandated that all physicians and staff must get a flu vaccination or face the loss of hospital privileges or employment
- Battle Creek Health System will have a similar policy in place for the 2007 – 2008 flu season
- Anticipate that as a next step hospital executives and medical control authorities will be discussing flu vaccine policies for EMS personnel
- In the Province of Ontario, Canada, two medics were recently suspended for challenging their service's mandated flu vaccination policy and refusing to be vaccinated
- Threats of a pandemic flu will keep a focus on vaccinations of all types for healthcare providers as Homeland Security, the Center for Disease Control, state and local health departments focus on planning for these threats (all have websites with their current recommendations for planning and very specific information on vaccinations)
- The board of directors of the Michigan Association of Ambulance Services adopted the Best Practice and disseminated it to all member companies
- The Chief Medical Executive of the Michigan Department of Community Health sent the Best Practice with a signed cover letter to all licensed first responder agencies in Michigan

Conclusion:

LifeCare Ambulance Service found that, with proper thought and planning, it is relatively easy to implement this Best Practice. It is supportive of healthcare professionals and their first priority in patient care, "do no harm". It is very cost-effective in terms of reducing overtime expenses and sustaining adequate staffing of ambulances during a flu outbreak. The bottom line: it is the right thing to do.

Bench Strength

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Through open dialog both of you can lay out some goals and expectations to prepare the successor. Be sure not to indicate that simply through the identification and development process, you are guaranteeing a future promotion, but rather simply creating options for the future.

If the potential successor agrees to be part of the succession program, work together to develop a written plan to prepare the successor appropriately. This may include formal education programs, workshops, job shadowing, internships at peer organizations, or any other developmental opportunity you both feel would be valuable. When establishing these goals, set reasonable time frames for completion, as well as a written expectation of how costs and logistics will be handled.

The last step in the planning process is to determine with the potential successor an estimated time frame to 'get ready', with specific dates for milestone completion. The overall development period may be six months or six years. The time does not matter as much as setting the actual goals. This way, the expectations are clearly understood on both sides.

Finally, you should ask all your managers to go through the same process, submit their written plans to you and make it part of their expected job duties. One promotion or change in the management team may create a cascade effect, requiring the most junior supervisor to have identified a few field providers who have been groomed, educated and prepared to become a field supervisor.

If you would like any additional information on succession planning, here are a few good resources I've found that may help you.

You may also contact me and I'd be happy to share with your some planning templates and tools for developing successions plans for your organization.

http://www.score.org/article_succession_plan.html

http://www.tva.gov/foia/readroom/policy/prinprac/intstaffplan1.htm

www.astd.org/NR/rdonlyres/8920CE23-5EA9-4C60-91A3-169CCB3C62DF/0/pp_GAO_HC_Report.pdf

Opportunities For Paramedics
WILLING TO STEP OUTSIDE THE BOX

By Pamela S. Davidson, CCEMT-P, Community EMS

In April of 2004, I began my employment with Community Emergency Medical Service of Southfield, Michigan. Since that time I have had many unique experiences. I began my career in Emergency Medical Service (EMS) in April of 1985, and have continuously sought out professional challenges. In November of 2005, I was presented with an exceptional opportunity to work in a governmental contract position as an Advanced Practice Paramedic in Iraq. Greg Beauchemin, President and CEO, and Diane Witkowski, Vice President of Operations of Community EMS, encouraged me to pursue this opportunity and ensured my employment by approving a one year personal leave. Community EMS has always been supportive of its employees and their desire to achieve professional success. Operation Iraqi Freedom and Enduring Freedom have presented this service with many challenges, as some were called to duty while others, like myself, sought to support this cause in the private sector as governmental contractors.

In the past 12 months, I have performed as an Advanced Practice Paramedic in a challenging and difficult environment, continuing to perform my job duties in the face of personal danger for extended periods. I have faced enemy action and weathered direct and indirect hostile fire, operating in a remote military camp in southern Iraq, one of the most environmentally inhospitable and violent locations in the world.

In a less than ideal work environment, I have learned more than I ever thought possible. I have had the opportunity to work with the United States Army on several critical issues, including emergency response planning. I also worked in a free clinic run by the U.S. Army which provided medical support to the Iraqi people and became the response hub for civilian? burn victims in southern Iraq.

Over the past year, I have operated a clinic as well as an emergency response ambulance supporting the U. S. Army. I never knew that these opportunities existed; there are many professional opportunities available to EMS professionals if we are willing to step outside of our comfort zones. I have learned that as medical professionals, we can expand our clinical knowledge and skill levels through service rendered in support of our nation on foreign soil.

In the course of my work in Iraq, I have had the opportunity to work with patients from North Africa, the Middle East, Central Asia, and the Indian subcontinent. Many of these cultures are sensitive when interacting with women in general, and as health care providers in particular. Through understanding, intellect, and good humor, I was able to overcome many cultural barriers, and I enjoyed the opportunity to partake in successful personal interactions with a wide variety of cultures.

In the past year, I have come to realize that even the smallest contribution can change another's life and, through this experience, I have helped enlighten many people about different cultural views.. I have seen how the Iraqi people live, and how little they have, and some of the challenges they must overcome. I have witnessed a people, proud and strong, who wish for change and have a desire for a better life. This is now possible as a result of their liberation. I have shared handshakes as well as hugs and tears with these people, and I now know that there is a greater purpose for our presence in Iraq.

I would like to thank Community EMS, Greg Beauchemin, and Diane Witkowski who encouraged, supported, and prodded me into an unfamiliar arena. I am grateful for this opportunity; I would have never taken this chance without the understanding and encouragement of my employers.

Pamela S. Davidson CCEMT-P, Remote Duty Paramedic Community EMS, Southfield, Michigan

Data Security in a Mobile Environment

By Dan Voss, Ortivus Product Manager & IT Specialist

Very few weeks go by when there isn't some type of story in the national news media about a laptop or backup tape containing lots of personal information being stolen or lost. As the trend to electronic patient care reporting software continues, there is a growing need for EMS providers to understand the risks and mitigation strategies for preventing the loss of personal information. While I will refer to laptops in this article, the same consideration must be made for backup tapes, flash drives, CD/DVD's and any other type of removable storage device.

This isn't the first time that our industry has heard about privacy protection. The EMS industry has been dealing with HIPAA for a number of years now, and HIPAA has rules about protecting Personal Health Information (PHI). HIPAA does mandate that providers protect PHI, but it generally doesn't specify how that PHI must be protected.

There is a new patchwork of state laws forming across the country of which EMS providers need to be aware. These laws are the Identity Theft Protection laws. These laws cover varying pieces of personal identity information, not just patient identity. Many of these laws specify not only what must be protected, but also how it must be protected to prevent the loss of this data from requiring the attention of your state. You likely only have one application that is responsible for storing PHI on your laptops, but you may have a variety of applications that store personal information that comes under the umbrella of the personal identity theft laws.

In general, the Identity Theft laws do not require businesses to do anything – unless they lose control of data that was in their possession. The requirements of what must be done once control of data is lost vary, but most laws require the business to notify the affected people that their identity information may have been compromised. If a large group is to be notified, the state may require that the loss of the data be made public through media notification. The state may also require credit monitoring be offered to the people affected.

Complying with these requirements can be expensive and embarrassing.

There are ways to avoid this embarrassment in most states with Identity Theft laws. Most of these laws waive the notification requirements if the data is encrypted.

So, is encryption the silver bullet that will kill the possibility of embarrassment and expensive notification procedures?
It may be.

But then the question is, what do you encrypt and how?

Is all of the identity information that you carry in electronic form in your patient care documentation software?

Do you carry an electronic address book on your laptop or PDA?
A list of names with addresses and birthdates qualifies as information that should be protected from identity theft.

This type of information can live in documents, spreadsheets, or other applications outside of the application that you use to document PHI.

Even if your existing application stores PHI in encrypted form, is that enough?

If application encryption of data isn't enough, what can be done?
Data security requires a layered approach.

The first layer is the physical layer. This may sound like common sense, but don't leave your laptops in unlocked vehicles. Use locking docking stations or cable locks to secure the laptop in the vehicle. This will help prevent the opportunistic smash and grab.

One might assume that the second layer is password protection. However, if the purpose of grabbing your laptop is to see the data that is on the hard drive, the drive will probably be removed from the computer and hooked up to another computer to access the files on the computer without having to break the password that is on the computer's operating system. You can compare this process to hotwiring a car. You don't need the keys if you can hotwire the car.

Once the hard drive is removed from the computer, encryption is your best protection. And, since it's difficult to know exactly where personal identity information may be living on your computer, the most secure method of encryption is to encrypt the whole drive. Having an encrypted hard drive is similar to having a vehicle that has a computer chip in the ignition key that must be present for the car to start. This makes hotwiring the vehicle much more difficult.

The Windows Vista operating system Ultimate and Enterprise versions offer a new feature called BitLocker that provides encryption of the system volume. Note that neither the Vista Business edition nor any of the Vista Home versions include BitLocker. If Windows Vista is not a possibility, there are other third party applications that can be purchased to offer similar protection.

If you can identify specific folders and files on your laptops that contain personal identity information that you wish to safeguard, then the Encrypted File System option available in Windows 2000, Windows XP, and Windows Vista may be a low/no cost solution.

Of course, all this effort for encryption is for naught if you do not protect your passwords. Let's use the car analogy again. If you leave the keys for your car in the ignition, it's pretty easy to steal. This is the same case with the data on your computer. Even with an encrypted drive, if the thief knows a valid username and password to access the computer then the best encryption technology may not protect your data.

In conclusion, if you want to do everything that you can to avoid being featured on the front page of the newspaper because of data loss, act on these three things:

1. Physically protect your computers.
2. Require the use of individual user names and complex passwords to access your mobile computers and their applications.
3. Encrypt the data on your mobile computers.

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Maximize Operational Efficiencies Through Accurate Deployment of Your Resources

By Stuart Erickson, Product Manager, Zoll Data Systems

The use of analytic models and tools in the planning and implementation of resources in an Emergency Medical Services (EMS) system allows for greater understanding of the interactions between various performance measures. The end goal of such models is to facilitate the effective and cost-efficient allocation of resources. Although the "science" behind matching supply with demand in EMS has been around for several decades, the tools for doing the analysis in a timely manner have only recently become available.

The History of High-Performance Emergency Medical Services

Research conducted during the 1970's to improve the efficiency of the Nation's EMS system concluded the following; that statistically, EMS demand was highly predictable and as a result, could be responded to with standard production model economics and systems/industrial engineering approaches and techniques. The legitimacy of the findings was enhanced in that the research also integrated the reality of the unique economic challenges of the EMS industry.

In the 1980's, select EMS organizations who continued to be challenged with significant systems problems, decided to rework their operational basis around this research. What resulted after a period of time was the first ever high-performance EMS system (HPEMS). Subsequent to the 1980's, additional systems began to utilize the concepts derived from the research in their own deployment methodology. These real life models have become the foundation of today's modern HPEMS systems.

Economics 101: Products, Supply and Demand

Economics is primarily focused on the issues associated with the production, distribution, and consumption of goods and services. The foundation of this field of study, of course, is the issues of Supply and Demand. Supply is basically the amount of something that is available to be consumed. Conversely, Demand is the quantity of some "thing", whether a product or service, that is wanted at any particular time. A common example of this that most of us are very familiar with is the fluctuation in domestic fuel prices associated with OPEC's changes in the production rate of crude oil. As less oil is available to be consumed, prices escalate, as more oil is available for consumption, fuel prices drop. Regardless of the business model, in a perfect world, equilibrium is reached when supply equals demand. These same concepts apply within EMS. At any one time of the day there is a certain demand for services (calls) and at that same point in time, there is a particular level of supply (vehicles available to respond). The research conducted in the 1970's was unique in that it recognized the similarities between what occurs within EMS relative to supply and demand, and hence, basic economic theory could be applied to understanding how best to get supply to meet demand. To fully understand the relationship however, another very important factor must be taken into account.

Is EMS a Service Industry or a Production Industry?

EMS is a production industry that provides its customers with a level of quality service as an end result of a quality product. So what widgets (or products) do high-performance EMS systems produce? A quality unit hour is the answer. A quality unit hour is an ambulance that is available to the EMS System for one hour that responds to properly triaged calls for service, is produced within a CQI environment that uses modern technology to collect and assess accurate data, is fully staffed, fully trained, fully maintained, fully stocked, properly placed in location and time, properly funded and safely operates within an educated population.

The EMS Widget: The Quality Unit Hour

A production industry that makes widgets produces and distributes (supply) their goods based on consumer consumption (demand) for their product. They use analytical tools to determine how many widgets to make, and where they need to be, in order to meet the needs of the consumer. Good EMS Systems do the same thing. Volumetric demand tells us how many UH's are needed by time of day (TOD) and day of week (DOW) and uses a temporal demand

Maximize • continued on page 14

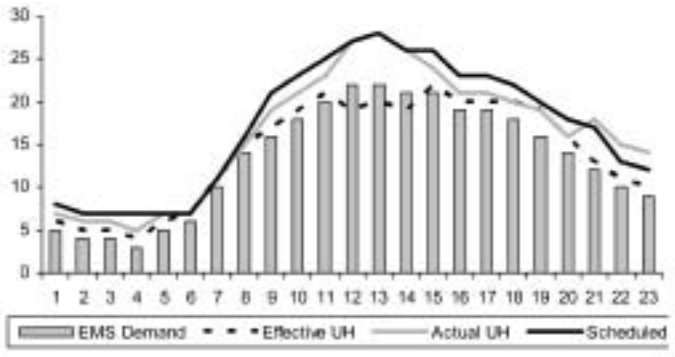
Maximize

Continued from Page 13

analysis. Geospatial demand tells us where UH's are needed by TOD and DOW and uses a geographic demand analysis. So what is actually being predicted here?

Human behavior patterns are quite predictable. These patterns vary by time of day and day of week. EMS systems only need to look at the calls generated by their patients based on their patterns of behavior. From this data, they can predict (based on history) where their population will be and how much service they will need for that hour of that day.

To provide a quality unit hour, an EMS system should utilize different methods, tools and measurements to help determine product quality, quantity and distribution of their goods to the market place. A production schedule is used to determine how many widgets to make based on an analysis of demand for their product. And actual production is used to determine how many widgets were actually produced (or made) by the factory according to the



production schedule. Lost production is used to determine how many widgets were actually produced based on the production schedule are lost due to poor product quality.

When plotted, as a function of call demand, the typical relationship between the different types of unit hours is shown in the following graph

The most important take-away from the graph is that Effective Unit Hours will always be less than Actual Unit Hours, which will be less than Scheduled Unit Hours. Much of this is driven by the issues of Effectiveness and Efficiency. Effectiveness is a measure of how close did a particular activity come to reaching the desired outcome. Efficiency is a measure of cost in terms of energy, cost, and time. In other words, did I accomplish what I set out to do and how competent was I in completing the task. For HPEMS, it means doing the jobs in the most timely and safest way possible.

HPEMS Production Problems and Their Impact

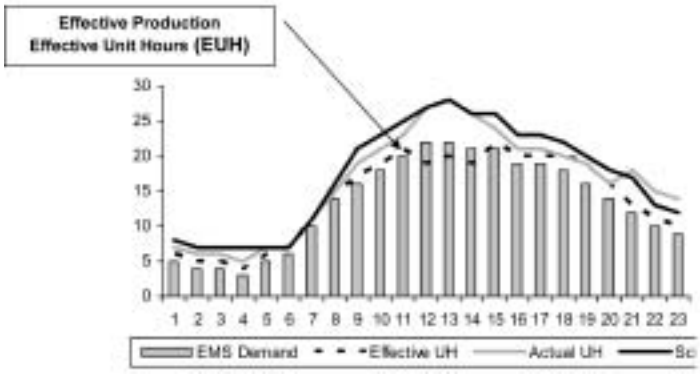
Various issues can come into play to cause problems in the production system of EMS. Errors in Scheduled Unit Hours can be a result of the schedule not matching demand, the schedule changed to meet employee needs or just plain inaccuracies in the schedule.

Actual Unit Hours can vary significantly for many reasons. Some of which are:

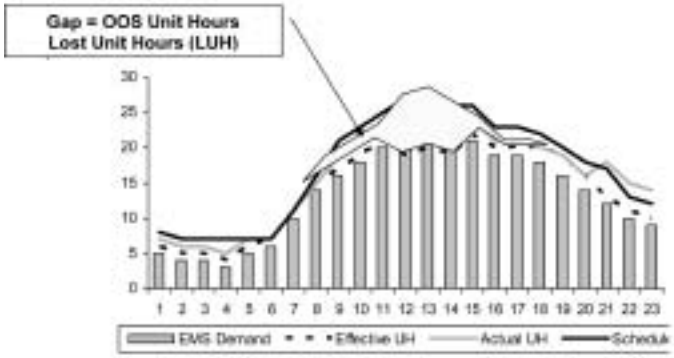
- Shift trades or shift variations causing over- or under-production
- Headcount/staffing problems
- Poor shift bid procedures
- Call outs/sick personnel
- Mismanaged PTO allowances
- Excessive LOA
- Excessive mid-shift changes

Lost Unit Hours can also be the result of many factors such as labor problems (work slow down), poor logistics such as equipment failures, poor maintenance, or poor mid-shift restock practices; maintenance problems such as fleet failures or a poor PM program; and systems problems such as poor procedures, policies, and practices. Often overlooked or under appreciated is the effect an organization's culture can have on Lost Unit Hours with issues such as employee favoritism, poor work ethic, and morale.

Effective Unit Hours are strongly impacted by LUH. To further



discuss the relevance of Effective Unit Hours we will further interpret the graph introduced on the prior page. Shown below is the same graph with the identification of the area of effective

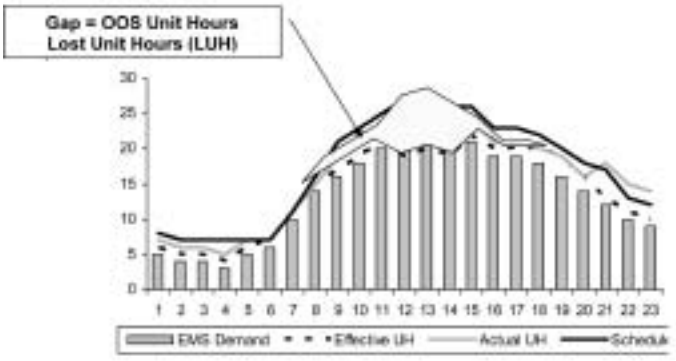


production; that is Effective Unit Hours are above Demand for that particular hour of the day.

Here we see the area for Lost Unit Hours or, as was mentioned above, the hours the organization paid for but received no benefit for. In other words, this is an area of inefficiency.

Perhaps the most notable part of the graph is circled below, and one that generally is unacceptable in EMS is an area where Demand exceeds the Effective Unit Hours. The interpretation of this area is that despite an attempt, and plan, to schedule resources of the level of

the solid black line, system problems have created a scenario where, due to Lost Unit Hours, the Effective Unit Hours is below the Demand. In this scenario, the system will not have sufficient resources to respond to calls for service.



In summary, most endeavors strive to produce a quality result while minimizing cost. Both of these goals are primarily driven by the issues of efficiency and effectiveness. Within EMS, where an organization is relative to those issues will define the type of delivery system they are operating under. Summarized here is the type of system delivered based upon how the efficiency and effectiveness of the particular organization.

High quality with above-average costs	***Effective but inefficient***
Low quality with below-average costs	***Ineffective but efficient***
Low quality with above-average costs	***Ineffective and inefficient***
High quality with below-average costs	***HPEMS systems: effective and efficient***

Only by adopting the methodologies of High Performance EMS will an agency achieve the best of both worlds; delivery of high quality medical care and a profitable business model.

Building a Schedule to Meet Demand and Peak Load Staffing – A Balancing Act

If done improperly, scheduling can cost an EMS system tens to hundreds of thousands of dollars. It also has the largest impact on employee well-being of any HPEMS concept/approach/theory, and patient care can be compromised if it's not executed properly. But if scheduling is done properly, it can save a system tens to hundreds of thousands of dollars (or more). It can also provide employees with shifts and options never before available, which improves employee satisfaction. And if done properly, it can significantly improve patient care.

Important things to remember when building a schedule:

- Start of shift and end of shift policies
- Fleet/supply/logistics capacities and reserves
- Simultaneous shift starts and ends
- Headcount/headcount/headcount
- Work rules and policies
- Internal and external politics
- Employee input and participation is NOT optional
- If employees are left out, your HPEMS project is at serious risk

Employee Input and Participation is a MUST!

Creating an employee scheduling committee is a good tool to foster participation. Ideally, the committee should be a diverse group reflecting as many special interests as possible (high seniority, low seniority, parents, singles, single parents, etc.) but limited to no more than four to six people. The committee's purpose is to obtain input from all stakeholder groups.

The Evolution of Deployment Planning Technology Solutions

As with other fields of study, the technology of deployment planning has evolved. As mentioned above, deployment planning has historically been done with colored pencils, graphs, lots or erasers and unfortunately, lots of time. With the proliferation of personal computers in the 80's and 90's, the process was made somewhat easier with applications such as Microsoft® Excel. But only recently have specific applications been developed for EMS that allow for fast and efficient resource planning. These latest applications allow for the rapid planning and the easy creation of multiple scenarios and more detailed analysis for determining the number of vehicles for a given time of day, as well as their geographic placement, or post. Development of EMS specific crew scheduling tools have also made the day to day management of operations more efficient.

AAA Welcomes Its Newest Members!

Advance EMS of Dixon, Inc.

Pepperell Fire EMS

West Springfield Fire Dept.

White Oak EMS

Lakes of the Four Seasons Fire Force, Inc.

Southern Care Inc. -- Wynne

City of Fountain Fire Dept.

Fire Dist. # 11 EMS

Woodruff County Ambulance

ParaBasic Ambulance Service

Lower Frederick Regional Ambulance Corps, Inc.

Friendship Hose Co. # 1, Inc.

Gordon Volunteer Rescue Squad

Oakwood Emergency Rescue Service

IL State Ambulance Association

The Louisiana Amb. Alliance

In Motion Technology

Tri-State Ambulance

Empire Ambulance

Professional Amb & Oxygen Srvc

Port Chester-Rye-Rye Brook VAC

Trinity Health Transit, LLC

Pre Hospital Management Systems Inc

University of Missouri Healthcare
Shawn Jackson
Eagle Ambulance Service

Beauport Ambulance Svc, Inc

Colucci & Gallaher

Emergency Medical Foundation

State Association News

**By Barry Albertson,
President of the
Ambulance Association of Pennsylvania**

PENNSYLVANIA IS IN THE PROCESS of rewriting the Emergency Medical Service (EMS) Act. Otherwise known as Act 45, the EMS Act was originally passed in 1985 and was in need of updating to reflect the 20 plus years of changes that have occurred in our industry. The Pennsylvania Department of Health went out of their way and sponsored statewide town meetings in 2006 to gather input for all Pennsylvania ambulance providers in their rewrite efforts. The rewrite of the Act has undergone 6 drafts since its original version was released in September of 2005 based on the feedback of the providers as well as statewide organizations, including the AAP. Members of the AAP Board of Directors reviewed the Act in detail and provided language suggestions and changes along with detailed rationale behind those changes. We have a great working relationship with the Department of Health's Bureau of Emergency Medical Services and will continue to work closely with the Bureau and Pennsylvania legislators as this rewrite moves along the legislative road.

The EMS Act is high on our legislative priorities along with Direct Pay. Direct Pay is an issue that has plagued our services for years and is one of the toughest to gain ground on due to the influence of the insurance lobby. This year will bring a new Insurance Committee Chair and hopefully some movement. Other avenues also being explored include direct dialogue with the Insurance Federation and the Insurance lobby.

We would be interested to hear what other states are doing or have done with respect to direct pay. You can contact our Executive Director, Heather Sharar, at (888) 262-9121 or executivedirector@aa-pa.org.

SELECT your Star

The American Ambulance Association's Stars of Life Celebration is the most rewarding and exciting national event in the industry. This special event recognizes and honors the dedication of ambulance services professionals — people that stand out in every area of the industry. You choose your "Star". These are the people who will be recognized in a celebratory weekend in our Nation's Capital.

2007 Stars of Life

"We're there when America Calls"

May 6-9, 2007
Washington Court Hotel
Washington, DC

REWARD

Reward and congratulate your outstanding ambulance service employees. Let your staff know that you are proud of the work that they do and how hard they work to support the high standards that you set for your company.

EDUCATE

Increase visibility to Congress on the role of ambulance professionals when you sit down with them face to face.

Spend a day on Capitol Hill educating legislators and their staff regarding the key role of ambulance professionals.

Generate national and local media coverage of individuals and the industry with your involvement.

General INFORMATION

The Washington Court Hotel is located in the exciting Capitol Hill neighborhood. Blocks from Union Station, The National Mall with the Smithsonian Museums (the popular Air and Space Museum pictured above) many of the national treasures and memorials including the Washington and Lincoln Memorials, the U.S. Capitol, Eastern Market (pictured below), the Library of Congress, the Supreme Court and the hangouts of the "Hill" crowd and much more.

Stars & Host Registration

Before April 6, 2007: $287.

After April 6, 2007: $402.

The registration fee includes all official events including orientation, seminars, receptions, awards banquet, a tour of Washington, DC, and an awards medallion and certificate.

Note: **Stars** registered after April 6 may not be included in the printed program.

Spouse, Guest & Alumni Registration

Before April 6, 2007: $165.

After April 6, 2007 $317.

Spouses and family members are welcome to join their Stars during their visit to Washington, DC. A guest registration fee is mandatory for each accompanying family member, spouse or guest. One tour is included but preregistration is required.

Sites Nearby our Hotel

Washington DC is a great city for people of every age interested in history, art, great food, nature, architecture and exhibits from many cultures and countries. We have been called the United Nations of Restaurants.

National Mall

The National Mall and Memorial Parks are responsible for over 1,000 acres of the most significant natural and cultural resources in the U.S. The "Mall" contains the cherished symbols of our nation, known worldwide and depicted on everything from currency to the nightly news. Close to our hotel, you will find the Smithsonian Museums, Washington Monument, the Lincoln and Jefferson Memorials, Ford's Theatre, Franklin Delano Roosevelt Memorial, the Korean War Veterans Memorial, and the Vietnam Veterans Memorial.

Smithsonian Museums

There are nine museums on the Mall including Natural History and Air and Space (pictured top left of page). Visit the newest museum, the Museum of the American Indian, right by our hotel.

Eastern Market

Eastern Market (pictured at left) is located at 7th and C Sts., SE, across from the Eastern Market Metro Station. It is open to the public every day except for Mondays. Eastern Market has long been an important element in the Capitol Hill community by providing a neighborhood market and a gathering place for residents. Eastern Market is one of the few public markets left in Washington, DC, and the only one retaining its original public market function. Food available every day and arts and crafts on Saturdays.

Washington Court Hotel's Accommodations

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Washington DC 20001

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fax 202-879-7918

The Washington Court Hotel on Capitol Hill is home to some of the most versatile and luxurious meeting facilities in Washington, DC., with elegantly appointed rooms, oversized marbled bathrooms and great views of Washington, DC. Contemporary, convenient and distinctive, the Washington Court Hotel is located on Capitol Hill only 3 blocks from the Capitol Building and 2 blocks from Union Station. To walk to the U.S. Capitol keep walking along New Jersey Ave., NW away from Union Station.

Reservations must be made by April 6, but the hotel may be full by then. Call directly and identify yourself as being with the American Ambulance Association to receive the room rate of $249.

The Washington Court Hotel offers:

- Bistro 525 Dining
- Federal City Bar & Billiards Room
- Business Center
- Fitness Center
- Complimentary newspaper
- A Gift Shop
- Video on Demand
- In room High Speed Internet
- Turn Down Service Upon Request
- VoiceMail and Dataport
- Walking distance to historical, cultural and government sites

CELEBRATE your "All-Star " Team

The Star of Life Program features meetings with members of Congress on Capitol Hill where the ***Stars*** themselves can share the reasons they have received their award and what they enjoy about working in EMS with the Congressmen and Senators. This is a very popular and important aspect of the event.

ENHANCE

The image of the members of the ambulance industry and AAA are enhanced by generating positive media coverage nationwide as well as in your local community. Each of you can receive media coverage for your company, and for your Stars through personal stories. This is how all of us raise the visibility of the important work we do.

RECRUIT

The honor of being recognized as an **All Star** is an outstanding recruitment and retention tool. What a way to congratulate your outstanding ambulance service employees!

The 2006 Stars of Life event was a first for Wake County (NC) EMS. As a sponsor, I was most impressed with the organization and hospitality of the event. My Star and I not only enjoyed the AAA festivities, but found the personal interaction we had with our Congressional representatives very rewarding. I highly recommend all agencies within the AAA to participate in the Stars program – not only to honor and recognize your exemplary dedicated professionals, but also to establish a rapport with those in Washington that represent the communities you serve.

Jonathan A. Olson, Division Chief

Wake County (NC)
Emergency Medical Services

Suggested *Stars of Life* Candidates

Any employee from your organization who epitomized the spirit and commitment of our nation's top ambulance service professionals is an appropriate selection (living or deceased). Paramedics, EMTs, dispatchers, customer service representatives or other operations personnel are potential candidates as Stars. For example, candidates may be selected because they received or were honored for:

- ☆ Employee of the year
- ☆ On-duty or off-duty services above and beyond the call of duty such as special rescues
- ☆ Setting of significant records
- ☆ Significant community contribution such as volunteer work
- ☆ Significant community distinction or honors related to ambulance, public safety, public health or health care services
- ☆ Consistent services record which exemplifies your ambulance operation's mission
- ☆ Local leadership in developing community partnerships with homeland security

What is the STAR of LIFE Program?

"The Star of Life experience was amazing. It was a great honor to be a part of the event."

"Meeting people from around the country allowed us to share our experiences and form a common bond."

Brianne Wiggins:
2006 Star of Life Recipient

All Star Kick-Off & Stars Orientation

The medal presentation ceremony kicks off the 2007 Stars of Life celebration. This memorable event is fun for everyone. We begin the event with the opportunity to introduce our Stars of Life, Class of 2007.

The orientation session that follows the medal presentation is an overview of the Stars of Life program. We include an update on legislation that affects your operation, your patients and your employees.

Appointments with Congress

It is important for members of Congress to know the role EMS plays in public health and public safety.

The AAA will arrange meetings for your Star of Life with his or her U.S. Representative and the two U.S. Senators from his or her state. Please note that we will be basing who the star will be meeting on the address provided on the registration form.

The AAA will be arranging only one Representative meeting per Star. If your operation would like your Star to meet with other Representatives representing your service area, please have a member of your staff arrange those meetings. Please submit the details of those meetings to Stacy Bromley at sbromley@the-aaa.org no later than April 30, 2007 so that the information can be included on the Star's individual meeting schedule and any scheduling conflicts can be addressed.

The Stars from each state will attend meetings with their Senators as a group. Most Stars will have three meetings. One meeting with a Representative and one meeting with each of their two Senators.

Recognizing and Rewarding Achievement

The Stars of Life is a special program. Its sole purpose is to publicly recognize and celebrate the achievements of all people working in the selfless and heroic ambulance industry. The Stars of Life Program seeks to honor outstanding individuals as a thank you for their service, their sacrifice and the inspiration they bring to all of us. The Program just as importantly seeks to honor these individuals as representatives or ambassadors of our industry so that the outside community and government agencies value the contribution they make to our neighbors every day.

This is a time for all of us to stand proud of what we do and to applaud those who set examples for all of us. View this event as not only a forum for communicating your appreciation for your employees but also as way for the outside world to recognize the value of our industry.

Flowers left at the Vietnam Memorial

Schedule of EVENTS

SUNDAY, MAY 6, 2007

8:00 AM – 5:00 PM	AAA Board of Directors Meeting
5:00 PM – 7:00 PM	General Registration
7:00 PM	Tour of Washington, DC (or evening on your own)

MONDAY, MAY 7, 2007

8:00 AM – 5:00 PM	General Registration
8:00 AM – 12:00 PM	Reimbursement Task Force Meeting
3:00 PM – 5:00 PM	All Star Kick-Off and orientation with U.S. Olympian, Dominique Dawes 1992, 1996 medalist, U.S. Gymnastics Team (Attire: Dress Uniform)
5:30 PM – 7:30 PM	Reception with light hors d'oevres and soft drinks
8:00 PM	Tour of Washington, DC (or evening on your own)

TUESDAY, MAY 8, 2007

6:30 AM – 9:00 AM	General Registration
8:45 AM – 10:00 AM	Group and individual photos at the U.S. Capitol
12:00 PM – 5:00 PM	Stars meet with members of Congress
6:30 PM – 9 PM	***Star of Life*** Banquet at the Washington Court Hotel (Attire: Dress uniform)

WEDNESDAY, MAY 9, 2007

8:00 AM – 5:00 PM	Stars meet with Members of Congress (All day as scheduled) (Attire: Dress Uniform)

EVENING TOUR OF WASHINGTON DC

An evening tour of Washington, DC is offered on May 6th at 7:00 PM and May 7th at 8:00 PM. The tour is included in the registration fee. Additional tour tickets are $26. Children over nine require tickets, children under nine do not, but everyone must have a reservation as the bus seating is limited to 60 people each night. Please indicate on the registration form which tour you prefer and the number of tickets.

Dominique Dawes

From Olympic Gold Medalist to Broadway to television analyst to President of the Women's Sports Foundation (2005-2006), Dominique Dawes continues on a path to inspire, motivate and lead.

Dominique burst into the international spotlight in the 1992 Olympics in Barcelona, Spain. She was the first African American gymnast to compete in an Olympic Games. At these Games she and her teammates captured a bronze medal. Since then Dominique has won more National Championship medals than any other athlete, male or female, since 1963, as well as numerous World Championship medals. One of Dominique's greatest feats came when she swept all four events and won the All Around title at the 1994 National Championships.

At the 1996 Olympic Games Dominique became the first African-American to win a bronze individual gymnastics medal (floor) and along with her U.S. Gymnastics team she made history when the team brought home the gold medal. Dominique has appeared on Broadway in the hit musical Grease, where she played the part of Patty Simcox.

Dominique enjoys being a spokesperson for many organizations and campaigns. Her appearances remain focused on youth and women's health issues and women's participation in sports.

Alabama
Alaska
Arizona
Arkansas
California
Colorado
Connecticut
Delaware
District of Columbia
Florida
Georgia
Hawaii
Idaho
Illinois
Indiana
Iowa
Kansas
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Michigan
Minnesota
Mississippi
Missouri
Montana
Nebraska
Nevada
New Hampshire
New Jersey
New Mexico
New York
North Carolina
North Dakota
Ohio
Oklahoma
Oregon
Pennsylvania
Puerto Rico
Rhode Island
South Carolina
South Dakota
Tennessee
Texas
Utah
Vermont
Virginia
Washington
West Virginia
Wisconsin
Wyoming

TRAVEL GRANT Program

Representatives from each of our 50 states, the District of Columbia and Puerto Rico are requested at this event.

The Travel Grant Program is designed to offset travel costs, especially airfare, for **Star** attendees. The estimated financial commitment from a company to sponsor a Star is approximately $1000. (including lodging, registration fees, but excluding travel expenses). The AAA Board of Directors has set aside $3000 to assist organizations' ability to send a employee.

We encourage those who need assistance to attend to apply for funding through this program. It is our goal to have at least one representative from each state.

If your organization would like to sponsor a **Star** and has limited financial resources, please submit up to two typed pages with your responses to the following questions:

1. Is this the first time your organization has participated in the Stars of Life ? ❑ Yes ❑ No
2. If you are selected to receive a travel grant, will your organization commit to fund the approximately $1000 fees required (excluding travel) to sponsor a Star? ❑ Yes ❑ No
3. Briefly describe the value of this experience to your organization: _____
4. Briefly describe the value of this experience to your employee(s): _____
5. Please briefly describe your organization's need for financial assistance and how much of a travel grant you are requesting. _____
6. What are the estimated costs for one ***Star*** to travel to D.C. (please itemize)
   - Airport parking _____
   - Ground transportation (shuttle or taxi) _____
   - Circle one: Airfare or Fuel (if driving) _____
   - Total _____
7. Please provide a brief profile of your organization (number of ambulances and employees, communities served, types of services provided, etc.) _____

If your travel grant is approved, we will notify you and an AAA check will be sent to you in advance.

Name of Company Contact — Name of Star of Life

Company Name

Company Address

City — State — Zip

Phone number — Fax — E-mail

Please return this questionaire with the ***Stars of Life*** application form to:

American Ambulance Association
8201 Greensboro Drive, Suite 300, McLean, VA 22102

Registration deadline for the Travel Grant Program is April 6, 2007

STAR, Spouse & Guest Registration Form

STAR OF LIFE'S NAME (First, Last) **Position**

Please write Star's name (above) and their company information (below) exactly as you would like it to appear as this information will be used for the Star's badge, award, and all official publications.

REQUIRED for possible visit to the White House (STARs only): Social Security Number for Star Date of Birth

Contact Person's Name (if "Star" will be a surprise) Title

Company Name

Company Address

City: State: Zip:

Phone: Fax: E-mail:

SPOUSE or GUEST of STAR REGISTRATION

Name (First, Last) Circle one for correct title: Spouse Guest

Name (First, Last) Circle one for correct title: Spouse Guest

REGISTRATION FEE (per person)	**BEFORE 4/06/07**	**AFTER 4/06/07**	**Number of People**	**TOTAL**
Star of Life Registration Fee	$287.	$402.	_____	$_____
Spouse/Guest Registration Fee	$165.	$317.	_____	$_____

TOUR REGISTRATION (Required)

REGISTERED Attendees, this fee is included. Non-registered guests must reserve and purchase ticket for $26. Guests under 9 are free. Tours are the same and are in the evening Tour A = Sunday, May 7; Tour B= Monday, May 8.

TOUR: Registered attendee(s) — Circle Only One	Tour A	Tour B	included	
Additional tickets for Non-Registered attendee	Tour A	Tour B	$26.	$_____
		TOTAL AMOUNT PAID		$_____

PAYMENT

❑ I am enclosing a check for $ _____ which represents at least 50% of the total amount due. I understand that the balance is due by April 6, 2007.

❑ Charge $ _____ to the following credit card: ❑ American Express ❑ Mastercard ❑ VISA

Card Number Exp. Date

Name on Card Authorized Signature

American Ambulance Association

8201 Greensboro Dr., Suite 300
McLean, VA 22102

Telephone:
1-800-523-4447
703-610-9018

Fax (only for credit card registration):
703-610-9005

www.the-aaa.org

FOR MORE INFORMATION OR TO SEND YOUR COMPLETED REGISTRATION FORM AND PAYMENT TO ADDRESS ABOVE.

Registration DEADLINE IS APRIL 6, 2007. Please return completed registration form by April 6, 2007 to avoid the late registration fee.

Please submit Star's biographical information directly via our website form: (www.the-aaa.org). Call AAA if you need the paper form.

Feel free to copy this form if you are submitting additional nominees.

HOST Registration Form

HOST NAME (First, Last) **Position**

Additional HOST NAME (First, Last) **Position**

Additional HOST NAME (First, Last) **Position**

Please write the Host's name and company information exactly as you would like it to appear as this will be used for the badge and all official publications.

Company Name

Company Address

City: State: Zip:

Phone: Fax: E-mail:

REGISTRATION FEE (per person)	**BEFORE 4/06/07**	**AFTER 4/06/07**	**Number of People**	**TOTAL**
Host Registration Fee	$287.	$402.	_____	_____

TOUR REGISTRATION (Required)

REGISTERED Attendees, this fee is included. Non-registered guests must reserve and purchase ticket for $26. Guests under 9 are free. Tours are the same and are in the evening Tour A = Sunday, May 7; Tour B = Monday, May 8.

TOUR: Registered attendee(s) — Circle Only One	Tour A	Tour B	included	
Additional tickets for Non-Registered attendee	Tour A	Tour B	$26.	$_____
		TOTAL AMOUNT PAID		$_____

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AMERICAN AMBULANCE ASSOCIATION

presents the

2007 AUDIO CONFERENCE SERIES

Valuable information without having to leave your desk!

Medicare Update, Repeat Admissions

Contracting for Information Technology

Leadership 101

Medicare Update

A convenient and unique way to update you on industry advancements.

Save these Dates!

Informative Audio Conferences conveniently presented over your office phone!

Conference calls last two hours with the average presentation time 1.5 hours. Handouts and call-in instructions will be sent via e-mail prior to the call from AAA's headquarter office.

Check out the Upcoming Topics:

Medicare Update, Repeat Admissions/Interrupted Stays and Other Current Medicare Issues

Wednesday, March 21

This conference will cover recent developments related to Medicare, including, but not limited to: recent denials for repeat admissions and interrupted stays (including strategies for handling current denials and denials retroactive to 2002); the discount issue (i.e. rates that can be billed to SNFs and hospitals); Carrier Jurisdiction (changes effective 1/1/08); changes in the Medicare Internet Only Manual; SCT coverage; new ICD-9 codes; issues A.A.A. is working on to resolve with CMS; a discussion of other relevant reports, studies, or opinions published by CMS, the IG or other federal agencies. If the GAO has released its cost study, it will be summarized and the implications discussed in this session. These and other issues, will all be covered. These critical issues change quickly and are relevant to business success — and compliance with the law.

*Presenter: **David M. Werfel, Esq.** is the Medicare Consultant to the American Ambulance Association. He is the author of the* AAA's Medicare Reference Manual for Ambulance.

Contracting for Information Technology

Wednesday, April 18

This session is designed to strengthen your ability to translate your business objectives into effective contract documents when your organization is purchasing information technology goods and services. This audio discussion will prepare you by proving a guideline and explanation of the critical legal and strategic issues that challenge ambulance companies when faced with the complex purchase of these technologies. Specifics common to this topic such as an overview of billing systems criteria will be covered. Key issues and risks, cover warranties, disclaimers, limitations of liability, acceptance testing and assuring compliance when they are within budget and schedule constraints are essentials will be components of this presentation.

*Presenter: **R. Michael Scarano, Jr.** is a partner in the Health Law Department of Foley & Lardner LLP, San Diego. Mr. Scarano has represented a wide variety of health care clients.*

Leadership 101— An Introduction

Wednesday, June 13

This session will cover the basic concepts in leadership and management. You will learn tools that you can use at your service for self evaluation, understanding the difference between leadership and management, leadership styles, common problem employee style, time management and mental survival as a leader.

*Presenter: **Aarron Reinert** is the Executive Director for Lakes Region EMS; a rural and metropolitan ambulance service. Previous to Lakes Region EMS, Aarron was the Field Services Manager for the Minnesota Emergency Medical Services Regulatory Board. He is practicing Paramedic, a regular educator for ambulance management, and a consultant for Public Safety Communications and EMS data collection.*

Medicare Update What's the Latest?

Wednesday, September 19

We know how limited travel budgets can be. Therefore, the AAA is bringing this session to you in an inexpensive mode. In this audio-conference, David will provide the type of Medicare Update that is presented at A.A.A. meetings. He will include the latest information concerning Medicare, CMS and its contractors, as well as any news concerning IG, GAO or other reports related to Medicare.

*Presenter: **David M. Werfel, Esq.** is the Medicare Consultant to the American Ambulance Association. He is the author of the AAA's Medicare Reference Manual for Ambulance.*

The last 30 minutes of these audio conferences will be for Q&A. Questions? Call 703.610.9000

Register Today!

Company Name

Contact Name

Address

City: State Zip

Phone Fax E-mail

MAIL TO:
American Ambulance Association
8201 Greensboro Dr., Suite 300
McLean, VA 22102

FAX TO:
703.610.9005

STEP 1: Check Specific Conference Titles Applicable

- ❑ **Medicare Update, Repeat Admissions**
  Wednesday, March 21
- ❑ **Contracting for Information Technology**
  Wednesday, April 18
- ❑ **Leadership 101**
  Wednesday, June 13
- ❑ **Medicare Update**
  Wednesday, September 19
- ❑ **ALL FOUR AUDIO COURSES**

STEP 2: Fill out payment form that corresponds to number of conferences chosen.

Member/Non Member	Price	Cost per session	TOTAL
AAA Member Registration	$105.	($105. for one session)	$_____
	$190.	($95. each for two sessions total)	$_____
	$270.	($90. each for three sessions total)	$_____
	$340.	($85. each for all four sessions)	$_____
AAA Non-Member Registration	$210.	($210. for one session)	$_____
	$380.	($190. each for two sessions total)	$_____
	$540.	($180. each for three sessions total)	$_____
	$680.	($170. each for all four sessions)	$_____

Join now & Save!
Membership Fees please check applicable box (see below for Membership descriptions)
❑ Active, ❑ Individual, ❑ Associate
❑ Affiliate, ❑ State Association
$_____

TOTAL AMOUNT $_____

An easy, efficient way for your entire staff to get ahead.

Save by signing up for multiple sessions!

Step 3: Fill out Type of Payment & Payment Information

❑ I am enclosing a check for $ _____

❑ Charge $ _____ to the following credit card: ❑ American Express, ❑ MasterCard, ❑ VISA

Card Number Exp. Date

Name on Card Authorized Signature

Types of Membership & Fees (V is a voting category, NV is a non-voting category)

❑ Active (V). Any organization engaged in providing fee for service ground ambulance transportation which meets the standards of the Board of Directors including government organizations, and is not eligible for other membership category. Annual dues based on the number of ambulances. Each ambulance is **$203.** with the maximum number for dues is 40 ambulances with cap of **$8135.**

❑ Multi-state Provider (with over 100 ambulances) – For the first state in which it maintains an ambulance operation, the ambulance service pays the base dues rate (which is equal to the dues cap) **$8135.** and receives five active memberships and five votes. In addition, the ambulance service pays a flat dues rate of **$1500.** for each additional state in which it maintains an ambulance operation. The service receives one active membership and one vote for each additional state.

❑ Individual (NV) interested in the medical transportation industry who doesn't fit another category. Dues, **$272.**

❑ Associate (NV). All other entities in the business providing ground or air services determined by the American Ambulance Association to be any of the following: 1) volunteer, 2) fire service and meeting the standards prescribed by the Board of Directors. Dues: **$749.** annually; except volunteers (50% or more unpaid labor), pay **$203**. for less than ten ambulances, more than ten **$406.**

❑ Affiliate (NV). Any person, partnership or corporation engaged in activities relating to or supporting the ambulance service/medical transport industry including manufacturing, sales, rental, training, and certification. Dues, **$1128.**

❑ State Association Member (NV) Any entity engaged in the business of providing member benefits to ambulance service providers for a specific geographic region in the U.S. State Association Members must meet the standards prescribed by the Board of Directors. **$267.**

Update your knowledge, network and be a part of new Medicaid reimbursement legislation

AMERICAN AMBULANCE ASSOCIATION

Summer Healthcare & Reimbursement Conference

NYC ❖ July 18-21, 2007

Come to NYC with AAA and keep up to date. Our focus is on our member's number one issue: REIMBURSEMENT

- Keep your business up to date with the latest on Medicare.
- Learn how to get paid for interrupted stays and how to reduce denials.
- Get professional updates and recommendations on: billing, changes in Medicare coverage, carrier jurisdiction, National Provider Identifier and more
- What do the recent activities and reports from Federal Agencies mean to our industry?
- Empire Blue Cross Blue Shield will share their perspective on improving your ability to get paid for claims.
- Be part of the attendee project to develop national standards for Medicaid reimbursement for medical transportation.
- See the latest industry products and services
- Join us in NYC for a Yankees game and other social events
- Network with the brightest minds in the industry.
- Help shape policy by participating in the Reimbursement Task Force meeting

AMERICAN AMBULANCE ASSOCIATION 2007

Please join us in New York City this summer for an exciting and information-packed conference targeted to your needs.

New York City, known as the city that never sleeps, will host our Summer Conference since it is a special city for AAA. During the 9/11 terrorist attacks many of our member companies provided assistance, care, and sadly several emergency medical service professionals' lives were lost.

With reimbursement continuing to be the number one issue for private ambulance service providers, on Saturday, Brian Werfel of David M. Werfel and Associates will present the latest information on Interrupted Stays and Reducing Denials. Prior to that, David Werfel will conduct two Medicare Update sessions providing updates on recent reports from Federal Agencies and their relevance, issues involving Medicare and recommendations on how best your operation can address them. These include billing issues, changes in Medicare coverage, Carrier jurisdiction, National Provider Identifier, Request For Proposals (RFP's) for carriers, discounts - court case, rates, claim forms, electronic claim attachments, SCT, ICD-9 codes.

The carrier for Empire Blue Cross Blue Shield will share their perspective. The types of denials they are experiencing, mistakes made by ambulance companies, how ambulance companies could most effectively get involved with their local carrier, the Request for Proposals for carriers/intermediaries and what they look for in processing claims.

During our luncheon, the AAA Data Work Group will present the much anticipated results of the GAO report on the cost of providing ambulance services as well as the findings of the AAA Cost Study.

On Saturday speakers from Page, Wolfberg and Wirth will conduct an all-day work session as well as present information about the current Medicaid system and gather input from the attendees with the goal of developing common standards for Medicaid reimbursement for medical transportation across the nation

On both days, our vendor member companies will exhibit their latest products and services.

Please be sure to attend at least one of our social events. AMBUPAC, AAA's Federal Political Action Committee, has organized an outing to a game at Yankee Stadium and Thursday, there will be a dinner cruise.

This conference promises to be educationally enriching as well as providing opportunities to network with some of the brightest minds in the ambulance industry.

AAA President and New York State native Jim McPartlon and I look forward to seeing you in the Big Apple.

Mike Hall

MTI Chair, Mike Hall

Be a part of a special work session about the current Medicaid system and gather input from the attendees with the goal of developing common standards for Medicaid reimbursement for medical transportation across the nation.

PRELIMINARY SCHEDULE OF EVENTS:

WEDNESDAY, JULY 18

8:00 am – 5:00 pm
Registration

9:00 am – 1:00 pm
Board of Directors Meeting

2:00 pm – 3:00 pm
MTI Committee

3:00 pm – 4:00 pm
Professional Standards & Research Committee

4:00 pm – 5:00 pm
Bylaws Committee

7:00 pm
AMBUPAC Event —
Sponsored by TransCare
NY Yankees vs.Toronto Blue Jays
Sign-up information will be sent at a later date.

THURSDAY, JULY 19

7:30 am – 5:30 pm
Registration

8:00 am – 5:00 pm
CAAS Pre-conference

9:00 am – 10:30 am
Legislative and Regulatory Committee

10:30 am – 12:00 pm
Membership Features Committee

1:00 pm – 5:00 pm
Reimbursement Task Force Meeting

7:00 pm
Social Event — to be determined

Please note: A large conference will be following ours at the Hilton in New York. The Hilton will not be able to extend the conference rate. If you wish to vacation in NYC, it is be best to so before the conference begins. Either way, please reserve your room as soon as possible as availability and rate are only guaranteed through the cut off date of June 19, 2007 and through our conference dates.

FRIDAY, JULY 20

7:30 am – 6:00 pm
Registration

8:00 am – 9:00 am
Continental Breakfast in Exhibit Area

7:30 – 8:30 am
New Member Breakfast

9:15 am – 10:30 am
Medicare Update I
Presented by David Werfel, Esq., David M. Werfel & Associates
Mr. Werfel's session will provide his recommendations and updates on issues involving Medicare. These include billing issues, changes in Medicare coverage, Carrier jurisdiction, NPI, RFPs for carriers, discounts – court case, rates, claim forms, electronic claim attachments, SCT, ICD-9 codes, etc.

10:45 am – 12:00 pm
Medicare Update II
Presented by David Werfel, Esq., David M. Werfel & Associates
This session will provide you with updates on recent activities and reports from Federal agencies, including the GAO, Inspector General (including Advisory Opinions), CMS, etc.

12:30 pm – 1:45 pm
Luncheon
Speakers: Jerry Zapotnik, Huron Valley Ambulance, Brenda Staffan, Rural/Metro and Randy Strozyk, American Medical Response
The RTF data group will be presenting the results of the recently completed AAA Cost Study. The study was commissioned by the Board of Directors of the AAA to provide a benchmark of information. The AAA will be using this data to analyze the much anticipated report from the GAO on Ambulance Service Costs.

2:00 pm – 3:15 pm
What You Can Do to Reduce Medicare Denials
Presented by Brian Werfel, Esq., David M. Werfel & Associates
This session will provide strategies to bill repeat admission and interrupted stay denials, clarify situations and insight on when and how to bill hospitals instead of Part B. Brian Werfel will discuss other leading denials followed by his analysis of how to prevent these claims from being denied.

3:30 pm – 4:00 pm
Refreshment Break/
Vendor time in Exhibit Area

4:15 pm – 5:30 pm
Ambulance Services – Carrier Perspective
Katherine Dunphy
Empire Blue Cross Blue Shield
In this session, you will hear from a Carrier's perspective what they see and hear concerning ambulance claims, e.g. the types of denials they experience, mistakes made by ambulance companies, how ambulance companies could most effectively get involved with a Carrier, the RFPs for carriers/intermediaries, what they look for in processing claims, etc.

SATURDAY, JULY 21

7:00 am – 5:00 pm
Registration

8:00 – 9:00 am
Continental Breakfast in Exhibit Area

8:00 – 9:00 am
State Association Breakfast

9:00 – 10:30 pm
Medicaid Summit
The session will present an overview of the federal Medicaid program and discuss the key distinctions from Medicare. A current "state of the union" in Medicaid reimbursement will be discussed. An overview of the new Medicaid Integrity Program and other fraud and abuse initiatives will offer providers the "heads up" on what to expect from this new federal initiative.

10:30 – 10:45 am
Refreshment Break in Exhibit Area

10:45 am – 12:00 pm
Medicaid Summit cont'd

12:15 – 2:15 pm
Lunch on your own/Vendor time

2:30 – 5:00 pm
Medicaid Summit cont'd

5:00 pm
Conference Adjournment

Please note: Presentations and materials provided by speakers at AAA events are not reviewed by AAA for accuracy and are the sole opinion and advice of that speaker and/or presenter.

Please fill this out and return to AAA

Company Name

Address

City: State: Zip:

Phone: Fax: E-mail:

First Conference Participant

Second Conference Participant

Third Conference Participant

	QUANTITY	BEFORE 6/18/2007	AFTER 6/18/2007	ON-SITE	TOTAL
AAA Member Single Registration	_____	$381.	$440.	$496.	_____
AAA Team Rate (2 or more participants)	_____	$341.	$440.	$496.	_____
Non-Member Registration	_____	$762.	$878.	$998.	_____
Membership Fees (please check applicable box see back of sheet for membership descriptions)	❑ Active, ❑ Individual, ❑ Associate ❑ Affiliate, ❑ State Association				$_____
			TOTAL AMOUNT		$_____

FILL OUT TYPE OF PAYMENT & PAYMENT INFORMATION

I am enclosing a check for $ _____

Charge $ _____ to the following credit card:

❑ American Express, ❑ MasterCard, ❑ VISA

Card Number Exp. Date

Name on Card Authorized Signature

MAIL TO:

American Ambulance Association
8201 Greensboro Drive,
Suite 300
McLean, VA 22102

FAX TO:

703-610-9005

"The American Ambulance Association promotes health care policies that ensure excellence in the ambulance service industry and provides research, education, and communications programs to enable members to effectively address the needs of the communities they serve."

TYPES OF AAA MEMBERSHIPS & FEES

(V IS A VOTING CATEGORY, NV IS A NON-VOTING CATEGORY)

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❑ Individual (NV) interested in the medical transportation industry who doesn't fit another category. Dues, **$272.**

REGISTRATION CANCELLATIONS FOR SUMMER 2007

To be considered for a refund, requests must be submitted in writing via fax 703-610-9005 or mail on or before June 30, 2007. Requests must be postmarked on or before June 30, 2007. Refunds requests will not be accepted after June 30, 2007. Not all requests will be granted. Substitutions for attendees are accepted at any time.

2007 AAA Calendar of Events

Mark your calendars for these events!

May 6 - 9, 2007
Stars of Life
Washington, DC

July 18-21, 2007
Summer Reimbursement Conference
New York City, NY

Oct 19-24, 2007
Annual Convention & Trade Show
Las Vegas, NV

Visit www.the-aaa.org for more information.